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ABSTRACT

Presented are a program description and the 1976 Annual Report of the Sharada Centre for the Non-Normal (mentally retarded) in India, a school which serves 50 mentally retarded children between the ages of 2 1/2 and 14 years. The program description gives goals of the program, the admission procedure, staff and teacher training information and a sample day at Sharada. Four case studies are provided. The Annual Report describes the B. M. Institute of which the Sharada Centre is a part, services to emotionally disturbed and mentally retarded children, professional education services, and clinical services including diagnosis-evaluation, vocational rehabilitation, and audiology. (DB)

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SHARADA CENTRE FOR NON-NORMAL

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Children, Teachers and Parents Learn Together.

Sharada is a specialised service of the B. M. Institute started in 1965 for the education and training of mentally retarded children. It has been financed by generous donation from Smt. Sharadaben Chimanbhai.

It is a place where children come together in an environment planned for their special needs, with workers (teachers) who want to develop appropriate modes to help them feel that they "belong", that they are important, that they can learn, and that people care about them. School and family work together to sustain and heighten the natural zest for life that a non-normal child should have.

With this underlying orientation, Sharada has gradually developed a therapeutic-educational milieu specific for non-normal children.

The professional link between the school and the Clinic for the Mentally Retarded of B.M Institute,enables regular diagostic and treament services to the retarded child. Individual and group counselling with parents is built into the extension services of the school.

Goals of the Educational Programme.

The Educational programme for the children of Sharada is based on the belief that a good school experience for any child, for normal and non-normal alike, is one that offers a growth-promoting environment. The programme, at the junior level therefore, aims in general to increase the children's range of interests, their span of attention, specific skills, and their desire to learn. Specifically, the goals are :

to increase language abilities through emphasis on socialisation, play, and improvement in speech and language.

to increase motor co-ordination and physical health through opportunities for climbing, jumping, sliding, running, cycling in outdoor play.

to develop self-care skills in cleanliess, food, toileting, grooming, household tasks, taking care of personal belongings, through participation in the ordinary day-to-day events in school and through consistent home training programme with young children.

to encourage social growth by providing opportunities for learning to share, to take turns and being an acceptable group member.

to develop sensory, visual and auditory discrimination by the recognition of likenesses and differences in size, shape, colour, sound and weight, through the didactic apparatus and also to learn their finer gradation.

to provide opportunity for aesthetic appreciation and creative expression through art, music, rhythm, puppetry and simple story telling

to develop pre-vocational skills and work attitudes through carpentry, sewing and embrodiery, weaving, arts, crafts, and home science.

to develop a work personality through participation in a work adjustment training programme as the students grow older.

to increase the individual's sense of self-growth which, we hope, will enable him to find a rightful place in his immediate group, his family and community.

This programme has evolved gradually as a result of direct experiences and detailed study of the children as they, individually and as a group, behave in the course of their daily activities in the school setting. On the basis of this close study, the programme is continuously evaluated in the light of the children's progress.

Secondary Stage of Education.

The children who have been at Sharada from the age of 8 or 9 years have reached adolescence. They have benefitted from the training programme as outlined. At the same time we had to shift the focus in favour of training them in skills which would eventually lead to their rehabilitation. Recognising the fact that any vocational programme requires certain amount of readiness on the part of the students, by the time they reach the age of 13-14, they are exposed to a pre-vocational training experience. The attempt in this programme is to develop a sense of discipline in completing a given task. This requires greater degree of concentration, higher application and better motor skills. Once the students complete this programme they are ready for training in vocational skills. Before determining the type of vocational skills they are suited for, they are subjected to intense vocational evaluation. Only then specific vocations are determined. In addition to offering them skills, the attempt is to develop in the clients what one can term as work personality. These young people, consistently, have had a feel of being limited in their capacities and incapable of undertaking complex tasks. The instructors and the counsellors have a responsibility to suppport them emotionally by constantly encouraging them, and developing their self confidence by exposing them to graded tasks. Only when they concretely see a completed job they can develop self confidence which can motivate them to further accomplishments. The staff is now evolving standardised procedures of vocational evaluation and determining the appropriate vocations to suit individual needs.

As the students become ready they enter the Vocational Training Unit-which is situated in the adjoining wing. Here the timings, studies and work situation are oriented to more structured atmosphere for work adjustment.

Admission Procedure.

Some of the considerations for admission to Sharada are : Groups are limited to manageable size; however a child may be accepted on the waiting list.

Custodial cases are not admitted.

Screening in the Clinic for the Mentally Retarded is required. Each applicant undergoes a thorough investigation, consisting of a pediatric, psychological, E.N.T. speech, occupational therapy, and psychiatric examinations.

In addition, a period of observation in the school setting is provided to determine more accurate placement. The obseravation is conducted by way of an unstructured play group program usually of a term's duration.

Mother, father, or both together are required to attend group counselling. Parents are also expected to be members of the Parents-Teacher's Association and to participate in the activities of the " Society for the Welfare of the Mentally Retarded. "

Clnic For the Mentally Retarded.

Over a period of years we have attempted to provide comprehensive services for the mentally handicapped patients. This may include referral to Sharada, a special school or provision of treatment in occupational therapy department where the treatment involves preparing the patients in activities of daily life, exposing them to specialized techniques to improve percepto-motor abilities or providing them with recreational programme in a group situation where they can develop social

skills. These programmes are offered both individually and in groups depending upon the needs of the patient. In some cases we have found that patients particularly belonging to the lower socio-economic group cannot attain the clinic regularly because of economic factors. In such cases, the patients are asked to come to the clinic once a fortnight or a month and at other times the clinic staff visit the homes of the patients and see that the programme outlined is carried on at home and also necessary modifications are made as and when necessary. In all these programmes, invariably, we attempt to involve at least one member of the family in the treatment procss so that the various treatment procedures can be demonsjrated to him/her so that the same procedures can be carried on at home. This has helped in maintaing the interest of the family members in the treatment programme and also eusuring continuity of the same. Such intensive treatment procedures require considerable investment of professional time and skilled personnel. Consequently, the number of patients who can be taken up for treatment is necessarily limited. Therefore, other services such as having time bound meetings with parents of mentally handicapped children where they can be oriented in managing the children at home, stimulating their skills in speech and language development, and motivating them to make better adjustment in the life situation are offered. In general, we can say the needs are enormous and all available community resources have to be mobilised to take care of these needs. Whenever we are not able to offer any services we refer the patients to other agencies.

The Children.

Children admitted to Sharada are between the ages of 2½ to 14. They are diagnosed and screened at the Clinic for the Mentally Retarded of the B. M. Institute and then referred to Sharada. They range in retardation from those who are mildly handicapped to those who are moderately retarded. But all of them still have room to grow in one way or another. None requires custodial care. A full day/half day programne is provided commensurate with age and readiness.

They learn in small groups geared to the specific need and levels of ability. Special teaching aids are provided for intensive training in language, speech and perception. Skills in reading, writing, number work are developed through concrete and repetitive exercises. Training in handwork suited to their abilities is given so that opportunities to extend them to vocational training in real job situations are possible. Vocational training emphasises the development of a work personality and skills leading to final placement and empolyment.

All the children play with a large variety of materials, both indoors and outdoors. They all go on short and extended trips to broaden their perspective of the world around them.

Growth in genearl well-being, self-help, motor coordination and social and personal awareness becomes the important link through which cognitive development takes place.

They learn to socialize not only amongst themseelves, but with children from a sister institution (Balghar) which is a primary school for normal children, in a variety of cultural and recreational programmes organised jointly throughout the year.

The Staff

The workers selected at sharada have to be gentle, patient and sensitive to the children's needs for protection and expressive outlets. As they grow older, the workers become aware of gradually minimising the retarded child's dependency needs so that he learns to be self-reliant to an increasingly greater degree. Their hope is to nourish and extend the gro-

wth of children (insofar as this is possible), who have suffered cerebral damage, environmental deprivation or other traumas which may have limited their capacities in one or another aspect of their growth.

Teachers and parents meet regularly to discuss the children's behaviour and progress. Teachers also visit at home during the school year, as well as work with parents of young retarded children through a regular home training programme. Parent participation in the school's aims is facilitated by a close relationship established between teachers and parents

The staff consists of full and part-time teachers who work closely with a psychiatrist, psycho-analyst, social worker, psychologist, E.N.T. surgeon, pediatrician, and speech and occupational therapists. The staff includes teachers for special subjects in Art, Language, Music, Handicrafts. As a team they study each child in detail. Regular conferences are held where children's progress, individually and as a group, is evaluated, and the school's programme is accordingly adjusted. It also enhances research in some of the aspects of mental retardation.

Health Check-ups.

Periodic health examinations are made by a pediatrician and an Ear, Nose and Throat Specialist. In addition, psychological evaluations are made periodically to assess change and development.

To supplement their diet, a nutrition programme has been devised. The children are provided fruits and biscuits as a supplement to the snacks which each child brings to school. Full-time children also have a balanced meal at lunch time. Around this programme, a whole range of activities in home science and kitchen management are being developed, especially for the girls.

Sharada and its wider activities.

No matter how good a programme for the retarded is, it has to be understood and appreciated by the community for it to grow. Consequently, the staff of Sharada maintains contact with local agencies in the city and with institutions for the retarded outside Ahmedabad. Staff members also conduct and participate in Seminars on Mental Retardation and in fields allied to it.

The Society for the Welfare of the Mentally Retarded (Ahmedabad) has been formed by the parents and staff of Sharada, and others. Now other institutions for the mentally retarded are members of this local society. Through this association, parents of Sharada children have an opportunity to widen their scope of concern in the problems of the handicapped, thus contributing to their own and their children's welfare.

Teacher Training.

A basic training program leading to a Diploma in Special Education of the Non-normal is offered in affiliation with Gujarat University. The course is aimed to inculcate in the trainee a capacity to observe how mentally retarded children perceive and cope with their environments. It enables the trainee to project his aspirations of what the child ought to be so that the child reaches out towards him.

The programe offers courses in work with non-normal children, specially mentally retarded, brain damaged, emotionally disturbed and multiply handicapped.

The training program is of one year.

Courses are offered in childhood education, non-normal children-their psychological problems, learning processes, special education and curriculum planning.

Admission requirements are: A Bachelor's Degree preferably with degree or diploma in educa-

tion and experience in regular or special schools or a child welfare agency.

Building

Built on the B. M. Institute campus, with shady trees and flowering shrubs, Sharada is located in one prominent wing of the Institute while Balghar (pre-primary and primary school) for normal children, occupies the other. Children from the two schools have their distinct educational schedules but have a common playground. Several festivals and parent meetings bring the two schools together. Teachers and parents alike are making an attempt to find out "how much" and "of what kind" of mingling is appropriate and possible for each of the group.

A large hall for dining and meetings, roomy covered areas for music, crafts and pre-vocational training, smaller classrooms for studies and cells for individual work provide accomodation for different programmes. Each classroom has an attached outdoor area for noisy activities and an enclosed garden safely allows for free play.

Future Plans

While the related programmes for the Non-normal will expand, service training and research will continue to be its components.

Moving towards the notion of a comprehensive centre for the Retardates, the programmes to be developed will include a Sheltered Workshop, recreational facilities and a place where the adult retarded can also belong.

A DAY AT SHARDA

To spend a day at Sharada with the children one would have to be prepared for 6½ hours of activities.

Fifty children varying in age study at Sharada. For music or meals they usually form one large group, while in their respective classrooms they break up into smaller numbers of fives to eights. On the playground the configuration is still different, some single out, whereas some move in pairs, some play around with an adult while some play on the apparatus.

Similarly the adults comprising teachers and mothers are either busy in classrooms, or in the meeting room with parents or in the kitchen preparing meals with children's assistance.

Whether in classrooms, kitchen or pre-vocational workroom, children tend to work individually, coping at their own pace and level of application. Despite high noise level one often comes upon a child who is silently occupied on his own in a quiet corner, with his work–or with a toy. He might be staying back to watch or might even be lost in fantasy.

The day begins at 9.00 a.m. with light breakfast followed by such creative activities viz. music, puppetry, and drama. This, perhaps, is the most popular activity. Apart from its informal, uninhibited, colourful nature, it is a very necessary tool for those children with speech defects as well as well as for others who are passive and need motivation. It's an excellent medium for breaking the ice.

Thereafter the children seperate into their respective classrooms for a period of learning on a more formal level. The program is somewhat structured and the least possible outside stimulus is introduced. It is this activity in the entire day during which the teacher and children "communicate" with each other or share an activity. Academic skills are introduced here and the entire hour is devoted to the learning ability of the children, with some time spent for gaining insight in coping with their emotions and feelings. This helps them in the process of personal and social adjustment.

Free play follows this session. The older children however, are taken up in the pre-vocational training programme in which carpentry, book binding, and weaving are introduced.

Those children whose free play session is over, start making preparations for lunch. This is an activity of importance as it enables the children to "organise" themselves and things around them in a more systematic manner.

During the lunch break younger children and those who participate in half-day programme go home. Others stay on for lunch and the rest of the afternoon programme.

While some children continue their pre-vocational activities, others rest, while yet another batch helps in the cleaning, washing,drying of utensils and sweeping and mopping the dining room. The importance of this activity is not merely as an activity, but one that enables children to recognize their sense of responsibility and manage the activity efficiently with little supervision. This improves their self-esteem for having accomplished a given task. It has a carry-over effect in the sense that the children even at home, so reported by the families, share in household duties.

The afternoon sees the children at various pre-vocational activities such as cooking, sewing, weaving carpentry etc, and arts and crafts. Cooking and sewing are particularly useful for those adolescent girls who are to be gradually prepared for a future vocation. The arts and crafts section tends to use painting of various types, waxing, paper designing, tie and dye processing and other methods of art to allow a free release of emotions to enable the child to feel an "urge to create" and to sensitize him to the more aesthetic aspects of nature and her creation around. The groups rotate monthly so that each child benefits or acquires the feel of the various activities.

All the above activities of a pre-vocational nature help develop skills and aptitudes in adolescent boys and girls, so that it helps them in the next step of rehabilitation which is vocational training, and which is provided by the Occupational Therapy and Rehabilitation Unit of the Institute.

Snacks follow, after which the children disperse having ended the day on an exhausted but nevertheless satisfied note.

Twice during the week, groups of children get an opportunity to channelise their creativity in pursuing, for leisure-time purpose, two activities-music and puppetry. While one group makes puppets and learns to manipulate them, the other group learns how to play various percussion instruments.

The above programme has been evolved to offer a comprehensive approach towards cognitive and social learning and emotional and interpersonal adjustment.

CASE STUDIES

Of the children referred to the Child Guidance Clinic, there were several who needed special facilities to learn, to train. The problem posed is how to go about it. At the B. M. Institute some theoretical orientation about the problems of retarded children was presumably available but this did not go far enough–we were poignantly aware that what we lacked was a feel, the sensitivity to understand and appreciate the retarded youngsters who were referred to us. Diagnosis by itself is not enough or doesn't carry you very far. For we are face to face with a child, a living being that perceives, thinks and feels and interacts with — The "Workers" had to feel their way before being in a position to offer a concrete programme. Thus, we were beset with many an unanswered question. Nevertheless we had to make a start. The simplest solution was to take such junior pupils in, to learn by being with them, by observation and introspection.

That is how the "Play Group" was born in November 1964, with a small group indeed. The experience we derived from their presence among us provided the requisite opportunities which would enable us to understand better the language of behaviour of the mentally retarded child.

The more formalised programme was launched in March 1965 by "Sharada" a special school for mentally retarded children. The initial admissions consisted of children mostly belonging to the severely retarded and some to the moderately retarded group. There were children with organic brain damage, with Down's syndrome, with cerebral palsy and other mental handicaps. To a lesser or greater degree all had some emotional overlay. They had to be classified not in terms of a rigid diagnosis but in terms of abilities and liabilities. In order to know them better we observed them in the school and at home. Out of this a progrmme evolved, not just on any specific doctrine but more as a result of experience.

A full-time school with lunch, opportunity for dressing, combing one's hair, brushing teeth and being familiar with activities of daily living in the day-to-day life made them specially aware of themselves as individuals. Pride in making ready to go to school for overnight stay and on short holidays together, added to their sense of finding a fit in the world around them.

In order to develop a commom language we had to build a team of workers who in the first three years would get an opportunity to 'Train' themselves with the help of the clinic team. Today the team includes special teachers (who are trained to work with handicapped children), parents, a full psychiatric team, a psychoanalyst, a speech therapist and audiologist, occupational therapist, paediatrician and E.N.T. surgeon.

The human factor "observing, understanding and relating" is perhaps the most significant one in enhancing the children to develop during their formative years at Sharada. That always remains the central core while the usage of tools such as psychological test materials, the psychiatric play-situation, developmental scales or the educational equipment gives a diagnostic cue regarding his strengths and failures. Each year every non-normal child undergoes a battery of tests as an evaluation procedure so that a proper record of assessment can be

maintained to facilitate comparison of his movement which further assists in planning the coming year's programme.

The caution of labling the children too early taught us, that like most children, even if the normal growth pattern does not have the same predictable value, the non-normal too, will have their spurt.

From the beginning we realised that whatever programme was offered, had to have the involvement of parents. Both parents and staff had to work cooperatively in order to understand what counselling meant. The attempt was to create an environment in the school and outside conducive to the child's optimal development. Counselling with the parents, thus, became an integral part of the programme at Sharada.

We started Sharada with young children around six or seven years of age, in what is known as the 'pre-primary' and 'primary' phase of development. Taking their time to grow, they move on to a secondary level of education which we call pre-vocational and vocational training. It prepares them in a total course of 10 to 15 years from the time they start, for a regular work situation of their choice. Managing their adolescent, young adult phase with its vicissitudes is what now becomes an important aspect of their growth that the teaching-training staff will have to help them understand and to live and grow with. The family also has a say in work selection and in what they accept to be the reality of the level of the students' achievement, which they have observed during the course of education at Sharada.

No one could imagine when we all started that the chidren had such potentiality. We were in for surprises, for in many instances we had underestimated their capacities. Somehow, after having been with them since their childhood, it was hard for us to appreciate that they were grown up. In our anxiety to not push them too hard, we tended to be over cautious in our demands. They surprised us by setting up goals and reaching them.

So as recently as in the summer of 1972 oldest children who have now reached the age of adolescence are introduced to a vocational situation where more serious attempt at training is introduced. Now their teachers are mostly occupational therapists, special teachers who continue to see them through their studies and other craft or technologically oriented staff with whom skills are sharpened.

They have come to this stage because of relationships they have developed with family members, the workers, and other children. We will never know what these relationships mean to them. All we can do is watch their observable behaviour. We have seen them over a period of 6 to 7 years. Had anyone asked us in the beginning how much of the difficulty the child experienced was due to retardation or brain damage, we would not have been able to determine the degree of emotional overlay. All we know is that they sought help and were able to use whatever help we could give. Our responsibility is to see that they are rehabilitated to whatever extent it is possible so that they can live with dignity. They are not emorphous, disorganised, aimless individuals any more. They have their own self-respect and have a will of their own. Looking at them gives us great encouragement and hope in what we are doing.

This presentation is prepared with the combined effort of the teaching staff. The English idiomoatic usage is less effective here, because the sort of "Gujarati-English" makes it more authentic.

The happenings described are real but professional ethics demand that the identity of the persons should not be revealed. Hence the cases are presented with fictitious names.

Since our approach to the problem involves working with professionals, parents, administrators, and educationists and interested laymen, this paper is addressed to all of them.

Let us take Jagu first. Despite his flightiness, he is able to become compassionate and helping companion of those who are in distress. Uday's expressive eyes when he approaches familiar people and withdraws within a shell when his anxiety is overwhelming. Pushpa, despite being clumsy and diffident in her behaviour opens up showing a great sensitivity when an understanding, empathetic person approaches her. Nothing can be more eloquent than Dilip's attempt to hammer a hail on a wooden board to the point of hitting the nail to be on the level with the board despite a gross tremor in his hands.

JAGU

.....And this is how it all began. With a certain amount of trepidation in my heart I took over the responsibility of "trying to understand" Jagu and thereby helping him to understand himself, his relationships and duty towards his family, his school and other members of his society.

It was a challenge too overwhelming for it meant a "change," not just in a superficial mode of behaviour, or in a cleaner pair of trousers, or even in unbitten finger nails, but in a more earthy, rooted sense. It meant more.....

It meant reaching out to those grubby hands and appealing to that wild, distant look in his eyes. But How ?

Jugu is a 13 years old boy who comes from a joint family of the middle income group. He was referred for his slow development in all areas, particularly speech and language. After evalution, a diagnosis of Down's syndrome associated with brain damage was agreed upon.

The family consisting of 3 children and the parents live jointly with the paternal grand-father who is retired. The house, fairly large and comfortable, belongs to him. The children are particularly attached to him, specially our young friend Jagu, who spends more hours with him than any other members of the family. The paternal grand-mother who is reported to have died of tuberculosis was said to be mentally deficient.

Father is a cashier in a local bank drawing a salary of Rs. 300/- per month. He is not a particularly assertive person, but although he takes a keen interest in his son's wellbeing, he entrusts the responsibility of Jagu to his wife. Maternal grand-father has been disturbed even before mother's birth and is said to require physical control. Mother has two brothers who earn reasonably well to maintain the family. At present the important individual around whom the family pivots is the paternal grand-father. He formulates ideas which are invariably followed. Though ideally a "grand-father," he nevertheless is a controlling force in acceptable social behaviour. He also is a "mentor" of the family from whom advice, knowledge and solace are sought.

Jagu has one elder sister who is at present studying in a local college. She is understanding and protective towards him. His younger brother causes a certain amount of rivalry between them. He is aware of Jagu's lack of speech and often mocks him. He plays similar pranks and teases him by hiding his clothes, toys and other belongings. Jagu has a little difficnlty in coping with him.

Mother had three miscarriages prior to Jagu's birth; each occurred at $2\frac{1}{2}$ months of pregnancy. She had also given birth to three children who had "some kind of fit," turned blue and died before they were hardly a month old. Thus, throughout her pregnancy with Jagu, the mother was gnawed by the fear of her child about to be born. She intuitively felt that although her child would survive, he would not be normal. Her intuition was confirmed when she realized that she had given birth to a mongoloid infant with a congenitally weak heart.

The child did not cry after birth for a considerable length of time, nor did he open his eyes for 10 days. The mother suspected that he was blind, but fate intervened and spared her an additional grief. He had repeated fever in a mild form followed by loose green stools. He was breast fed up to 18 months and semi-solid foods were introduced but the child could not digest them till about 2½ years. Weaning was achieved with considerable difficulty.

Developmental milestones are as follows :

teething at 2 years
crawling at 2½ years
sitting after 3 years
walking when almost 4 years.

Jagu attended a balmandir for a year at the age of 6, which he obviously enjoyed very much. He was unable to work at the didactic apparatus, but mixed easily with his peers as well as his elders by way of teachers.

He used to take some eatables to school but was unable to eat properly without the teacher's help. On the whole he enjoyed his one year's stay at school.

At the time of clinical diagnosis Jagu was subjected to certain tests, both to assess his physical growth as well as mental development. In 1966, his I. Q. was determined to be 30, which approximately meant that at 5 years his mental level was like that of a 2 years old child. However, this cannot be taken literally but rather as a guage to understand our young friend. The pediatric test confirmed his retardation and also suggested consultation with a skin specialist for his 'alopatia' (uneven and scanty hair growth).

In 1966, his E. N. T. report showed that there was no evidence of impaired hearing, but rather a retarded speech development that was confined to mere monosyllables.

In 1967, his I. Q. proved to be the same and it was not until 1968 that it rose from 30 to 35, during which time he had been attending Sharada for two years. His mental age also rose from that of a 2 years old to a 3 years old child. The programme apparently helped him.

When Jagu was admitted to Sharada at the age of seven the initial observation was that of an extremely hyperactive, aggressive, destructive boy, unable to sit at a task for more than a minute, and whose inability to verbalise caused much concern to his family. He was also unable to go to the toilet on his own, wash, clean, brush his teeth or even comb his hair. He was not able to button his clothes or put shoes and sandals on the correct foot; and he could not differentiate between the outside and inside of clothing. Moreover, he was extremely untidy in his food habits, besides being unaware of his appetite-eating anything, any amount, any time.

The problems presented were many, and it was thought at the time of diagnostic evaluation that Jagu would eventually benefit from Sharada's programme, to which he was duly admitted.

Jagu joined Sharada on 1-8-1966 and was admitted to the "Nursery Group." He was given training in feeding habits and attending to his toilet. Play with emphasis on constructive socialization was encouraged. He was exposed to didactic apparatus and stimulating activities like music, puppetry and drama for release of aggression and anxiety.

In the beginning, he had a certain amount of difficulty in mixing with the other children, but took no time in adjusting to the school situation and programme. He would, however, get easily distracted and distract others along with him. He was unable to complete a given task and was extremely restless. His attention or concentration span were negligible.

He enjoyed outdoor activities very much, but would tend to manoeuvre the situations often so

that he would spend more time outside than inside the classroom. He had difficulty in sharing toys or equipment with others and his frustration tolerance was low.

Initially in a one-to-one relationship with an adult, Jagu found companionship and a beautiful language system where along with sound-cum-gesture-cum-expressive conversations of telling and responding were held by the two in a meaningful relating way. His winning smile, impish character and easy lovingness made him into a very desirable person. He had the charm to win over adults, specially those who knew him in a one-to-one relationship, for they attracted one another as if each one had found himself. Gradually, Jagu began to shape and formulate his moves, ideas and desires into something more constructive. He began to take active interest in arranging, organising, cleaning up, putting away things, and above all in himself. He soon won friends over to his side and gradually took it upon himself to be a "leader." This was the beginning of a more "organised" Jagu in terms of discipline. He started "feeling" for others, sympathized with little ones who may have fallen from a slide or been scolded for playing mischief. It was the beginning of a realization of others other than himself, and this gradually began to gain momentum. He still remained disinterested in indoor activities or remained indifferent to didactic apparatus. He preferred to circulate in company and thereby socialize.

By the time he left the "Nursery Group" of children and entered the "Pre-primary Group," Jagu was a more stable, confident boy, who had achieved a certain propriety in eating and going to the toilet; and who remained reasonably clean throughout the day.

It was at the "Pre-primary" level that Jagu underwent a certain metamorphosis mentally and physically, emotionally and discipline-wise. The new programme was gradually stretched to a full day, introducing varied activities of a stimulating, purposeful and creative kind. A sense of "choice" was awakened in him; in other words, he gradually began to discriminate between situations and ideas.

Throughout this period, consistent emotional security, disciplined handling, and parental advice were given. Parental attitude had to be changed in order to meet Jagu at his level.

The worker had to be sensitive enough to appreciate him in diverse moods and situations. She constantly modified the management techniques to suit his specific temperament, maintaining consistency. Gradually Jagu began sensing right from wrong in situations and acts of behaviour. He became constructive and even creative. He showed tremendous enthusiasm to please the worker by attempting various tasks, thereby his aggression and anxious preoccupation of a ruminative type got channeled. He not only felt important, but also made others feel he was so.

Music was his favourite activity, and running close seconds was arranging the physical set up and training programmes in specific tasks. The fact that he became more organised in his activities provided a certain sense of shape or formation in mental attitudes and ideas.

He took keen interest in art and craft activities like painting, paper-cutting and dyeing. He also enjoyed pre-vocational activities, specially those relating to wood work, where he found himself completely immersed in "hammering" out his aggression.

Surprisingly, he became enthusiastic about learning how to read and write. Perhaps, it was his desire to prove himself a more important, worthwhile individual, in whom a certain amount of ability in reading, counting, writing was necessary. This desire led to imitation, which gradually started forming a need to identify himself with older, more responsible persons.

Towards the end of the first term in 1972, it was decided that Jagu was ready to leave the "Pre-primary" level and enter the "Primary" phase.

His family feels more confident of him now and has begun to realise thet Jagu certainly proved a better child than they had ever imagined. The parents, specially the mother, have given untiring support emotionally to him and perhaps it is correct to say that today the mother is reaping the rewards of her difficult and devoted efforts.

Jagu is at present in the "Primary group" where he spends more time at learning tasks, writing and counting, where he is thrown with older, more stable children, and thereby has to merge and compete with them for a proper status. His hours of pre-vocational activity will also be increased in due course as he is able to stand the pressure of more work. His sense of responsibility, enthusiasm to do well, confidence and honesty with himself, have gone a long way into shaping Jagu into what he is today, at 13 years of age.

Jagu needs to be handled and thereby understood with patience and sensitivity. He needs approval for his work and a sense of confidence and belief in him. He is a child **who should not be experiemented** upon by introducing a task he is completely incapable of doing, as his frustration will come forth and he will remain disturbed for a considerably long time. One can achieve a better result from him, if confidence and belief are put in him during a particular activity. It is **very** important to note that excessive physical strain should not be allowed as he has a congenitally weak heart.

The journey is not at an end, there can be no halt, for it is now that Jagu will be able to look back on those years he spent in banging doors, smashing glass, hammering nails into boards, causing a tremendous amount of sorrow to those near him and today feels a sense of triumph, achievement and a "little" greatness on his part.

UDAY

Uday is a 13 years 9 months old male child who comes from a lower middle class family. He was referred to the clinic at the age of six with referral problems of inability to study, obstinacy, incoherence of speech and disturbed sleep.

Uday belongs to a lower middle class nuclear family consisting of the parents and three children which include Uday, his younger sister and brother. Parents were married in 1958 through personal choice. They separated from the joint family almost a year after their marriage, when Uday was 8 months old.

Mrs. S. has both her parents. She is the second eldest among 5 siblings–3 sisters and 2 brothers. Her elder sister who is married has been rejected by her husband and therefore lives at present with her parents. The youngest two, a brother and a sister, are emotionally disturbed. The brother, a psychotic, has a history of convulsions at the age of 5 and at present his behaviour has been described as destructive and bizarre. The sister is mentally retarded.

The entire family especially Mrs. S. shows considerable anxiety lest Uday may take after his maternal uncle, considering the onset of the convulsive attack was more or less the same in both. As Uday frequented his maternal grandparents' place, Mrs. S. was afraid he would pick up similar destructive traits.

Both parents of Mr. S. are living. He is third among seven siblings which include two elder brothers, two younger sisters, and two younger brothers. One younger sister apparently turned "insane" after pregnancy, while the other remained unmarried. Two elder sisters are married. Mr. S's younger brother is married staying separate from the family. Another younger brother is a student. Mr. S. has received education up to the 4th std., which incidentally is less than Mrs. S., who is educated upto the 7th. Mr. S. at present is serving in a book-seller's shop,

The paternal grand parents and Uday's family live in the same neighbourhood but have separate residences. Paternal grand mother, it seems, needlessly interferes with Mr. and Mrs. S's household. All the same Uday is more attached to her. Paternal grand father usually stays with his son except at meal times.

Prior to Uday's birth Mrs. S had a miscarriage, Mrs. S. was 21 when she conceived Uday; she did not welcome the pregnancy, but did not resent it. Uday was an unplanned baby and was born after Mrs. S had suffered from severe bleeding for 1½ to 2 months. She has faced a similar problem in the other pregnancies too. During the 8th month, Mrs. S. had typhoid, as a consequence of which she was completely bed-ridden for 21 days, she was hospitalized and was also under constant heavy medication. Besides typhoid, she also had high blood pressure. It was a full term normal delivery after 2 hours of severe labour pain. It was conducted in a hospital. Uday weighed 5½ 1bs. at birth, looked weak, and his skin was loose and wrinkled. There is a history of two major illnesses in early childhood, diphtheria at the age of 1¼ years, when he was hospitalized and cured within a couple of days, and then chicken pox at the age of 1½ years with mild fever for seven days. In his

early childhood he was also frequently susceptible to coughs and colds. At the age of five he had a severe attack of convulsion, which lasted for ½ hour.

Sitting was accomplished at 7½ months. He did not learn to sleep on his stomach or to crawl. Standing was accomplished at 1 year, walking 1½ years. He started babbling at 4 years and toilet training was achieved by 3 years.

Prolor to his coming to Sharada, Uday had had a brief school experience in two different schools. At the age of 4, he was admitted to a balmandir. He enjoyed going to school and there were no complaints from school regarding his behaviour. As he was left handed, attempts were made by his father to enable him to write with his right hand. This probably created more confusion as a result of which he was unable to write at all. After the severe attack of convulsions, his P. G. M. insisted on his leaving the nursery. Nevertheless, he was admitted to a municipal nursery school, after a short interval. The admission was obtained through his maternal aunt's influence. Scholastic performance had improved here, in that he was able to count up to 100.

The first psychological test conducted on 9.12.64 revealed him to be an anxious, angry, negativistic, withdrawn and silent boy. Initially his lack of cooperation prevented the psychologist from making a precise assessment from the Goddard Form Board and Shukla's test. Two years later when retested his mental age and I. Q. were assessed to be 3½ years and 48 respectively. His chronological age was 6 years 9 months. Subsequent tests were conducted at intervals of 6 moths which revealed his mental age on an average to be 4½ years indicating brain damage with severe emotional problems.

Voice was found to be hoarse, speech moderate, hearing good. Tongue and lip movement is good. Dental hygiene is poor. Comprehension is good.

His pediatric evaluation indicated that he was undernourished. At the time of his admission to Sharada in 1965, when he was 6 years old, Uday could be described to be a nervous, frightened, anxious and also an extremely stubborn child. Both parents were rather concerned about his aggressive behaviour as he tended to beat and push other children. In time this seemed to have gradually stopped, causing relief to the parents for they had always connected Uday's aggression with maternal uncle's insanity. His obstinacy and demands often led to frequent temper tantrums, specially at the time of dressing where he was rather choosy about his clothes.

Uday would spend more time with his grand parents and less at home. He was afraid of his father's temper which often took the form of beating or nagging. Mother's attitude and behaviour on the whole depicted her to be a person who lacked warmth and understanding towards the child. His reaction and behaviour towards his younger sister could not be said to be very affectionate, showing considerable reluctance to play with her or fondle her. During his brief stay at the municipal school he had made a considerable number of friends whom he would invite home. He had even made attempts to study, and would constantly have lessons from his maternal aunt but had difficulty in retaining what he had learnt.

He could recognise and remember his relatives. He was able to identify pictures of various animals and even spot out his uncle's car which was one amongst several of the same colour. However, he was unable to recognise coins. As far as his daily activities were concerned he was totally independent and self-reliant. He could fetch simple household articles and follow simple instructions.

He could button and unbutton his clothes and dress, himself, but was unable to tie a string. He was able to differentiate between the right and the left shoe, distinguish between outside and inside of clothing.

However his mother did express his lack of understanding and judgment by giving the example that he had shown no reaction when he was suddenly switched over to bottle feeding.

According to both parents his long absence from the nursery school was also a reason why he had forgotten most of the things taught to him. He was able to travel alone in the neighbourhood especially to his grand parents' house, with great caution while crossing roads. With the hope that the programme would benefit him eventually, the professional group decided to admit Uday to Sharada.This took place in 1965 when he was almost 6 years. When he was first admitted to the "Pre-primary" group, he was particularly exposed to socialization, feeding habits, speech training, motivating him through music and other stimulating activities and introducing him to appropriate didactic apparatus. A simultaneous home training programme was undertaken. The tense and anxious mother was seen by the social worker with the hope that she would in time have better understanding and acceptance of her child.

During these early days one would find him to be very inhibited, isolated and quite obsessional in his play, repeatedly making temples with sand and bricks and performing puja. His need for affection and security from elders manifested when his long skinny arms would reach out to caress and envelop them. His joy and excitement when he had anything important to say was displayed by his hopping around the place with a sparkle in his eyes and his speech becoming mumbled as if he could not say it fast enough. These were often in alternation with a tense and an envious look on his face, showing considerable distress when things at home were in a bad shape. Remaining disturbed the whole day, repeatedly mentioning incidents that had occured at home reflected in his behaviour the strained atmosphere of home. About the time there were many disturbing conditions and events which filled the little boy's life and which overwhelmed him and he showed confusion, restlessness and became distracted. They lived in appalling poverty in a single room apartment which had a tiny hall in front and a kitchenette in a building on the opposite side of the street connected with a passage. (This style of living is quite characteristic of the city in its densest areas). Suddenly one day this part of the house where the kitchen was, caved in and had fallen and became detached. Also about this time the grand father had died and there was a birth of a sibling. Uday's family had an anxious time. Mother was often impatient to take him home early in order to cope with her chores as she seemed to have little time for Uday or leisure for herself. She often threatened to burn him with a match-stick if he did not respond immediately. She was angry and quick tempered most of the time when she fetched Uday from school.

In due course Uday seemed to settle down in the school during the morning programme. He had gradually become less inhibited, mixed with other children, enjoying music sessions and even communicating more freely. He had gradually left off playing in the sand and preferred indoor activities. As he grew older, around the age of 10-12 he entered the "Primary" group. Uday now began to have a sense of belonging and made friends with a couple of children.

The "Primary" group however, saw Uday through many trials, tribulations and eventually a reconciliation with himself, his work, his family and his goals. The main emphasis during this period by the worker was to bring about a sense of achievement, judgment, and confidence within himself by binding his free-floating anxieties. This was achieved through a continued therapeutic and supportive approach. Apart from the routine work, the worker tried to increase his level of aspiration towards a more ambitious goal in order to help him develop a sense of self-confidence. She tried to keep him occupied either by giving him certain tasks or by distracting him from the anxiety-

provoking situations he mentioned regarding home. His work hours were gradually increased by his admission into the pre-vocational programme. This proved a valuable source of occupation and a useful tool for allaying his fears. He developed interest in his work. Now he found pleasure in being independent and gradually he even journeyed to school and returned home by himself.

Uday discovered a special friend, who like him had remained isolated. Anil too had been in school as long as Uday. They became an inseparable pair, enjoyed partnering each other for several months. While Anil made quick progress in studies and started verbalising (he had developed elective mutism), Uday freed himself to move into a steady work situation. In their closeness a certain sense of intimacy and belonging evolved which enabled them to share and experience mutuality. After a certain phase of togetherness each one was enriched sufficiently to allow him to work as an individual in his own right.

Meanwhile the worker continued counselling with mother, who could gradually see her own involvement with the child and how this in turn affected his behaviour. During the course of counselling her outbursts were frequent, nevertheless worthwhile, for they told of many sad and unhappy incidents in her life. Many were related to her husband, to his insecure job from which he was in and out repeatedly. They earned little and did not nave enough to eat. The anxiety to make both ends meet was a continuous external factor that made their life difficult. As things lightened for her she was able to have a fresh look at her suspicion and pre-occupation that Uday might have inherited the insanity and the retardation of family members.

Uday used to help mother in household chores and thereby another dimension of relationship was available to them. Thus, on may occcasions Uday would come to school tired and when asked why he began the day in this manner, he would triumphantly reply that he had been helping his mother to store water, make tea and clean the house. The beginning was thus made and the dawn of reconciliation long awaited had eventually become a possibility.

Gradually, what the husband was unable to fulfill Uday was able to achieve, a steady conscientious flow of support and help. His understanding of the family situation increased and with the meaningful activities, a more lively group of friends and the support of the worker, he tried to blot out his failures and prove a more worthwhile son of his parents. Even during the school vacation, he would go with his father to the book binder's and learn the task, in order to give a helping hand to his father. He shouldered responsibilities and was able to fulfill the desires and hopes that his mother had. His efforts were unfailing and despite the occasional aggressive outburst from his father, he would keep his spirits up.

Soon the day came when the worker thought that Uday was in a position to be adequately independent, intellectually more alert, emotionally more secure and responsible, confident and mature and with a sensitivity towards his family and himself. She therefore suggested a promotion to the 'Intermediate' group where he would spend more hours constructively at a given task and side by side concentrate more on reading, writing etc.

Today, at 13 years Uday appears more stable. An emotionally secure atmosphere at school and his more accepting home, have given him a sense of identity which he can use. He goes about his work independent of constant help and is thus able to achieve better. He is at present in the intermediate group where his hours in learning and pre-vocational activities have increased. He seems to have fun and enjoys his present situation, where he takes several decisions for himself, and sometimes for the group also.

Regular inspiration in his work and appreciation alongside, can go a long way into shaping Uday into a more secure and confident, young person. He has another seven to ten years of vocational training at Sharada before he will go out into the world in his own right.

PUSHPA

Pushpa, was first referred to the B. M. Institute by a local analytically oriented doctor in July 1962, and again by our our own social worker in June 1969. The following were the referral problems :

Failures in school, disobedience, an outsider in play and very attached to parents.

Father complained that Pushpa is mentally retarded and her mental age is not coming up in spite of making efforts. Having had psychotherapy for 1½ years, with the referring doctor, Pushpa was referred to our clinic. Since leaving school, where she had studied upto Std. II, Pushpa was at home. At the time of second referral she was completely fed up and bored being at home. She always forgot what her father taught her, and became confused and constantly upset. During this time her sister, six years younger, did well and went ahead of Pushpa.

This is an unitary family consisting of father, mother and a younger sister. They originally come from the Eastern region but have lived in Gujarat for many years. They live in a pleasant residential locality in a compound consisting of a few bungalows; theirs is the first floor flat, which has three rooms and a kitchen. The home is adequately furnished and well kept.

Father is the head of the family. Father, a well educated man is lightly built, in his early forties, works as an executive in a local firm. He conversed mostly in English and described mother to be a 'slow' complsive person, ascribing much of this beaviour to a low level of understanding. Pushpa, in his opinion resembled mother.

Mother 10 years younger is a non-matriculate housewife, of average height, a clean looking complexion, large greenish eyes and pretty features. Both of them and the children dress well. Mother does not feel comfortable unless she cleans the house first and then starts cooking.

This becomes the subject of conflict between her husband and herself as this delays his going to office. Parental conflict and dissatisfactions make Pushpa anxious, and, until lately, she often came to school upset and tearful. If taken aside she would pour out the cause of her being upset.

Her younger sister, Reshma was 10 years old at the time of clinic referral in 1969 and was studying in Std. V at the same school as Puhpa in Ahmedabad. She is good looking and resembles her mother, having a clear complexion and light eyes but in contrast to Pushpa, she is intelligent and jolly. Reshma does not include Pushpa in her play nor takes her out when she goes out with her friends. However, since Pushpa's joining Sharada. Reshma has become more tolerant of Pushpa and though she provokes her at times, she also attempts to patiently teach her embroidery and enagages her in conversation. Often she accompanies Pushpa to school whenever there is transport dificulty. In short she attempts being sociable, and provides companionship.

The parents married in 1955 and a year later Pushpa was born. Mother was 20 years old then and enjoyed good health during pregnancy. Delivery took place in a hospital and was normal. Labour pain lasted hardly for half an hour. Pushpa was born after 8 months, 10 days and weighed 6½ lbs. The parents expected a boy, but accepted the baby girl as well. Mother does not know if the baby cried after birth.

Her developmental mile-stones were delayed. She learned to sit at 12 months. Being bulky, she tended to sit at one place. She learnt to stand at 2 years, and started walking at 2½, but it was only at 6 to 8 years of age that she could walk steadily. Teething started at 11 months and completed by 3 to 3½ years. She was toilet trained at 2½ years. Learnt to babble at 2 and spoke in sentences at 3½ years.

As she had a squint since birth, she was operated at 6 to 6½ years of age. When the child was 1½ to 2 years old she cried incessantly, and was spanked by mother in anger. The child developed temperature alongwith diarrhoea and vomiting, which led to mother's feeling guilty. This illustrates the paradigm of mother-child relationship.

Pushpa was admitted in school at 5 years. It took her 3 months to adjust and she used to cry a lot. She could not grasp anything and repeated each class twice. Father would coach her at home but she could not grasp anything. Some improvement was noticed following the eye operation, but after six months she was the same. Then father started consulting doctors and came to know that Pushpa was mentally retarded. She could not write due to tremors in her hands. She studied up to Std. II and then the school authorities advised her removal from a regular school.

The test report at the time of evaluation indicates that she came out with many disconnected thoughts and resisted giving detailed information. Her ideas and thoughts suggested her disgust in staying at home and wish to come out and play freely.

On Bender Gestalt Test her performance was poor. Visuo-motor perception was on the level of a 7 years old child. and suggested emotional disturbances. Her behaviour on this test indicated the presence of underlying problems of impulse control associated with brain damage, though no definite sign of possible neurological impairment was available. On Draw-A-Man's Test and Bhatia's Test also her performance was rather indifferent. In general her performance was placed in the level of educable retarded. On TAT her spontaneous stories did not reveal much. Her approach on all TAT cards suggested low mental functioning and poor imagination. Slight depressive elements were noticed in some of the stories.

She was last tested in 1971. A very striking feature was her relating to the examiner with smile and giggles at almost every point. She reflected a strong need to please him and satisfy herself by attempting to be accurate. On Bender there was better control over her movements, cleanliness, and accuracy. This can be taken as a sign of her settlement in the environment and development of confidence in her self. The record still reflects clear indication of brain damage affecting visuo-motor development.

In comparison to the structured situation, in which she was in control of herself, the present situation showed her to be overwhelmed and confused in her responses. It was with this view that the Rorschach ink-blot test was selected. The quality and quantiy of her Rorschach responses reveal a potential to relate with other persons. The reproduction of colour naming responses indicate her tendency to express her emotions in an uninhibited way. An indication of free-floating anxiety and undercurrent depression affects her potential functioning capacity. However, her interpersonal relationship is not hampered.

Pediatric examination revealed her to be overweight. At the time of E.N.T. examination, ear drums were found intact and hearing was within normal limits. Dental examination did not reveal any clinical condition. The opthalmologist has examined her and prescribed bifocals.

Pushpa was admitted to Sharada on Ist August 1969 at the age of 12½ years. She was described by her parents as being obedient and truthful. At times, she would get upset and emotional. Because of hand tremors and being slow she was unable to help the mother in household chores. She would get bored sitting at home and many a times she would become the cause of parental quarrels. When the younger sister was given attention, Pushpa would feel jealous and hurt when she was not included in play activities. In the schools she was found to be gentle, friendly and outgoing. She usually was protective towards younger children. Though she enjoyed the various activities, her chief problem was getting mentally ready for the next activity. This was particularly noticed when, on coming to Sharada in the morning, she would delay in joining for snacks almost as if she would want to gear herself to the day ahead. This problem continues but to a lesser degree. At times, she would come upset from home and then would find herself faced with difficulty in adjusting to group demands. On such occasions, she would become particularly sensitive to the slightest provocation. She would have a trying period when the more aggressive boys would provoke her.

At home she had certain compulsive habits of spending her time, for instance in preparing the school bag. She would tend to get anxious and worked up which especially manifested itself at home when school trips or school overnight programmes were planned. In other words, she would feel anxious to separate from her parents, she tended to be over careful about her belongings in case she lost or misplaced them. When the article was found, she would feel embarassed that she could not control herself. In the course of working with her, the worker helped her in gaining an understanding of her anxieties. It was in the last term of 1972 that Pushpa for the first time felt secure enough to stay overnight at the school. However the home or school situations often continued to overwhelm her and she would seem confused; at the same time she showed sufficient insight, thoughtfulness and tolerance. On the whole she was still overshadowed by feelings of insecurity and inadequacy which took often the form of negativism.

During the summer vacation of 1970 she and a few other Sharada students were admitted to the short Vocational Training course of the Occupational therapy unit.

Gradually with one to-one relationship she became more spontaneous, developed a sense of humour and was able to take a wider social role. As time passed, she was found to be calm and steady and whenever she got upset, she gained control within a short time. She would at times use physical symptoms as a means of drawing adult attention. For instance, she would complain of a stomach-ache or a head-ache whenever a task lay ahead of her, but would forget it during the course of the day, when she was occupied.

She was always singled out in the learning area, because her medium of instruction was English, while other children studied in Gujarati. Attempt was made to teach her in Gujarati but due to poor percepto-motor abilities she had difficulty in reading and writing of the local language. With constant effort on her part she became neat in her writing and improved considerably in arithmetic, however, her reading and spellings were poor. She has accepted punctuality through consistent training in starting her activity on time. When she tended to mainpulate situations, by making excuses and delaying others in learning, the worker was particularly firm. This consistency has helped her to settle down sooner in learning or work activity than before. Also as she began to participate in the pre-vocational training, it provided her satisfaction from various work activities and she could now undertake responsibilities willingly. There was also some improvement in her co-ordination, but she

continued to be a slow worker due to poor muscle power and visuo-motor incoordination with persitent tremors.

Puspha's overall adjustment still remains precarious. She can be friendly, cheerful and pleasant with others, yet easily slips back into indifference and depression particularly when she cannot work. Also she becomes evasive and easily frustrated. Negativism seems to take the outer form of what appears to be the core of an insecure, diffident youg woman whose impaired percepto-motor co-ordination keeps her slow and "behind" others.

Her hand tremors continue to a lesser degree, yet quite obviously. Now the mother involves her more in household tasks after continued parent counselling, but she lacks confidence in her ability to work on her own unless mother approves and supervises.

Having a friendly disposition, she enjoys visitors but at times, she is unable to assess how much time she should give in talking with them. Many times now she is able to control her impulse to leave her work and go with them to show them around Sharada.

Being an adolescent, there are times when she feels shy and awkward to approach or ask permission from certain workers. At other times, she disapproves behaviour which she feels is exhibitionistic. She also tends to be quite persistent in her judgment. No amount of explanation or discussion would change her way of thinking which she feels is right. For instance, when Mala, her class-mate, does not respond to her friendliness and keeps quiet because she is out of mood, Pushpa feels upset and hurt and firmly thinks that Mala will not talk to her. Only later she understands that she was not the cause of Mala's unfriendly attitude. Though her own attitude reflects immaturity and pre-occupation at times with an upsetting situation, the intensity and its duration are much reduced.

When three senior pupils of Sharada were given a certificate and congratulated on their having completed their programme in Sharada and were being referred to the Vocational Rehabilitation Unit of the Institute, Pushpa came to the worker's side and asked her quietly, when she would graduate. The worker told her that her next goal should be to qualify for this project and that meant working towards it. She smiled, nodded and went away.

Work becomes the most meaningful activity for Pushpa. Much of her boredom, indifference, general lascitude disappear when she is engaged in work. However, her capacity to respond and apply vary from time to time. She needs to be constantly motivated with an adult worker indirectly supervising and guiding her. Otherwise she gets distracted and loses interest. A more significant change appeared when there were some staff changes. Pushpa went through three months of varied behaviour. On some days, she would work better and on other days she was totally indifferent and least motivated. In pre-vocational activites like weaving, she tends to be slow on the uptake and needs intensified practice to improve her co-ordination. Though she learns the various steps she seems to need assistance. In preparing afternoon snacks she can follow oral instructions much better than in other activities. She is aware of safety and protects herself to a much greater degree than is necessary. Her fear of fire has reduced now.

In general activities, she takes care of personal needs, goes to assigned groups or activities with less resistance than before, carries out assigned tasks when sufficiently secure and motivated, learns new tasks and improves upon them with practice, recalls tasks she has learned. In physical productivity she tries out but the degree is less than before. Usually, when she does not enjoy a task like washing dishes or mopping floors, she tires easily. Though her energy level has improved it is less for her age. The team has felt that after all this work Pushpa is ready to go into a vocational training programme. Experience in working with her has indicated that she will not function under pressure. She has a distinct mind of her own but is receptive to suggestions, provided they are made with understanding and she is allowed sufficient time to accept them.

DILIP

This particular case has been with us since the inception of "Sharada, School for Mentally Retarded Children" and was simutaneously registered in the Clinic for the Mentally Retarded of B.M. Institute. For the sake of convenience let us call this case "Dilip". Dilip was registered on 1st April 1965 by his father at the age of 8 years 5 months with the complaints that he is not able to learn in normal school, has muscular inco-ordination and a back history of Epileptic fits which ceased by 1963.

Looking into the family history and social background of this case, one can say that Dilip comes from the typical average lower middle class family where his father is engaged in a modest business of selling savories. They have a joint family with about 21 members. Although there is a paternal grandfather aged 70, to look ofter the welfare of the family, Dilip's father is the main person. He does not have any formal education Dilip's mother is a middle-aged lady who has studied only upto Std. II. After her marriage she has almost constantly been bearing children. She has delivered nine children and out of them, the last child expired on 26-3-65 at the age of 1½ years due to unspecified fever. So Dilip now has five sisters and two brothers and he is the third issue of his parents.

Dilip lives in a flat which is a combination of two one bed room flats and is in a compound which has about 48 tenants. He has a good social group to live and play with and has ample play area around his residence, although it is deprived of any special children's park in immediate vicinity.

The initial impression of the family at Intake was that his father was not a very happy man, though he dictated authority in the family. Dilip's mother was found to be a person who took orders for duties from her husband. The relationship and warmth between the parents appeared lacking. Dilip's mother appeared to be accustomed to remaining in the background, not only out of custom binding upon female members, but because of her husband who dictates the terms. There was a general look of apathy and disdain in the parents.

The medical history of Dilip reveals injury on the labour table. He weighed 10 lbs. at birth. Upto 4 months nobody noticed any problems with him. Then parents noticed that the child did not move like normal infants of that age. He remained limp like a bundle of muscles and bones. Soon medical help was sought and treatment was given. At the age of 6 years he started getting Epileptic seizures which were controlled.

Reviewing the clinical picture, when Dilip came for help at the Institute, one finds that he was identified as a case of cerebral palsy with mental retardation. He showed choreo-athetoid movements with affected gait and posture and torticollis (wryneck). He was suspected of extra-pyramidal involvement. In spite of all these difficulties, Dilip was very likable, full of life and enthusiasm and was always ready and eager to relate with new people and new experiences. Dilip established his standard of performance and a value system of his own and insisted that his achievement be of high quality. An example may be cited to elaborate this point. When he was learning how to nail on wood, he was clumsy in his movements and would make attempts to nail the pins on the point at correct angle.He would struggle hard to be sure and feel

for himself whether the surface of the wood was smooth after completion of the job. This particular zeal and drive for perfection has been an important factor in the development of his good work personality. On psychometric tests, he was found to be functioning 5 years below his level with an I. Q. of 40. He was recommended for admission to Sharada, school for retarded children.

Although his speech was much affected, still he never got desperate and patiently tried to communicate. He tended to say things so fast that he often found spit escaping from his mouth and landing all over the listener. But he would hold on to the listener till he completed his message-comments. He was expressive and communicative. He also showed a tremendous need for an adult relationship and a consistent environment. It was this need for emotional warmth from other persons that probably made him so sociable. He was equally possessive of especially one young male teacher who was adored both as a friend as well as a hero. But he was only "his" teacher. If he gave attention to another child, Dilip threatend to get his father remove him from this school for "Mentally Retarded Children".

Sharada proved to be a rich source of emotional warmth and a consistent milieu with a wide variety of sensory-motor exprience. He participated in the sensory-moter training group, socialization programmes like music, puppetry, picnics, group work, etc. and graded teaching programmes much influenced by Montessori and Steinerian approaches. Dilip, as he was entering his adolescence, showed marked improvement in his personal, social and learning areas. However, his eye-hand co-ordination still affected his performing to the optimal level. Still the improvements shown in all the areas were encouraging. He had learnt how to make parcels and packages of savories sold at his father's shop. He had also mastered the technique of mixing raw materials in the preparation of savories. He was now so confident of his independent performance that sometimes when he got angry towards his father or other family members, he would say that "I want to start my own business and I will have my own mobile shop for selling savories. So that I don't have to depend so much on you." This small incident reflects to a great extent the emotional indepenence of this boy and his capacity to perform as an individual. Speech therapy assistance was also started simultaneously to improve his verbal facility.

Soon it was realised that Dilip should be helped in his percepto-motor area, his faulty posture and muscular inco-ordination if he has to perform better in the advanced area of learning and performance. His basic skills, aptitudes and interests should come to some consistent level, to take advantage of pre-vocational programmes and other rehabilitation measures. With this understanding, he was referred to the occupational therapist attached to Sharada school.

The Occupational therapist on evaluation found that Dilip was performing much below his potential because of his percepto-motor difficulties. It was further confirmed that although there was no spasticity, Dilip had some vestigial traces of tremors and his tilt of the neck was not torticollis but a compensatory adaptation due to rotation in the axis of vision on account of involved orbital muscles of the eye. Also due to this abnormal positioning of the neck, there was a compensatory kyphoysis of the dorsal vertebrae and increased lumber lordosis. His sustained suction and blowing were much below the norms, explaining his faulty explosive and strenuous speech. Individual therapy for Dilip was started by the Occupational therapist focussing on percepto-motor, relaxation and breathing exercises. He was involved in activities which facilitated the reciprocal movements of the limbs.

Simultaneously, Dilip started participation in a pre-vocational evaluation and training programme. The work oriented programme focussed much of his energies towards a structured task and these

experiences gave him a motivation to pull himself up and step into the adult role of the work-day-world.

In the terminal phase of the pre-vocational programme, we found that Dilip had now started crystallising his work personality in a definite usable form and had attained sufficient control on his impulsivity and short attention span. He could adequately and meaningfully participate in a programme of an advanced nature, like the vocational rehabilitation programme. Keeping into consideration the family business of preparing and selling "savories" and the possibility of self-employment in his own family business, a lot of encouragement and opportunity were provided to him so that he could participate in his father's business activity at different levels and simultaneously he was exposed to kitchen work. He mastered quite a number of basic skills required in the kitchen. Now Dilip has been referred to the vocationol rehabilitation services of the Institute to take advantage of a comprehensive rehabilitation programme. Presently he functions at an educable level with high scoring on social maturity and a good level of performance. He has an aim in life and a realistic ambition to take up an active role in his father's business.

Dilip's case is a good example which illustrates how phyaical handicaps and percepto-motor problems can affect the performance of a child to a degree that he almost functions at a poor level. But if given a proper milieu and consistent therapeutic approach, a case like him can come out of the dark world of misery, frustration and failure and participate in the warm bright experience of the world which beams on his face.

Name	Sharada
Address	B. M. Institute Navrangpura Ahmedabad–380009 Gujarat State. [INDIA]
Telephone Number	54726/7/8
Medium of Instruction	Gujarati
School time	9.00 A.M. to 3–30 P.M.
Fees	Rs. 120–360 per term for full-time children, including 2 snacks and lunch. Rs. 71–196 per term for half-day children, including one snacks. (Based on income)
Terms	June to October — 1st term November to April — 2nd term

The programmes at Sharada are recognised by the Central and State Department of Social Welfare, Government of India.

ANNUAL REPORT

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"Time and experience . . . alter all perspectives" – Henry Adams

Although my association with B. M. Institute is in its infancy, I have been privileged to be given some insight into the principles which have motivated the development of services. 25 years of growth has produced an influential voice in the community and country. Development is the important factor in the emergence of the B. M. Institute.

Development falls into two categories: fact and theory. In the development of the B. M. fact and theory have been combined. Facts become meaningful only when they are bound together in terms of principles which are basic and fully understood by those involved in the work. What are these principles?

1. The basic interest is the development of oneself as a working and contributing member of a group. An institute, like a family, is composed of persons who are bound together by the interest of self-development.

2. The need for the expansion of the 'self' through some satisfactory participation in work within the group.

3. As areas of work develop, there arises the need for trained persons.

4. The more these trained workers invade the community demand such services. As a result, the B. M. is composed of a number of professional service units and facilities. The clinical professional units cover psychiatry, psychology, occupational therapy, speech and hearing, social work and documentation. To these has recently been added an education unit which combines teachers from Balghar, the school for the normal child, and Sharda, the school for the developmentally handicapped.

The personnel of the clinical units provide clinical service to all children enrolled in the schools. Adolescents and adults are also seen through out-patient admission. There are new developments in infant care, educational planning and training; and a new work world is opening up for the adolescent and adult who are handicapped. All these new directions are the result of interaction between the institute and the community. Striving for a wider understanding of human development will make the helping professional better equipped to deal with problems presented to him. This continuous acquisition of a wider perspective represents a conquest and a challenge.

What, then, is the positive goal inherent in our perspective?

1. Mental health services for children is still insufficiently appreciated in the community. The plan must be to prevent, detect and diminish or completely eradicate mental illness in children.

2. As awareness of the importance of education grows in a country, the chances for good education seem to diminish. Classes are over-crowded and the child who lags behind falls by the wayside. A program of remedial education is required.

3. Because, in all fields, knowledge is rapidly expanding, the opportunity to keep abreast of develop-

ments must be provided. B. M. Institute has one of the most sophisticated libraries to be found anywhere; use must be made of it.

4. Research must be seen as a reliable tool with which to find facts that release us from the bonds of theory.

5. There must be education about education, or the planned promotion of an educative environment in and around the family, home and school.

We must examine these considerations and thereby meet and conquer our challenges.

Mrs. Thelma McConnel

INTRODUCTION

The B. M. Institute was established in 1951, by Smt. Nirmalaben Bakubhai. It was conceived as a center for the scientific study of children in all aspects. Since those early days the Institute has evolved in various ways, but its basic premise has been that human behaviour may be viewed as a resultant of multiple dynamic forces. Man strives to maintain an internal harmony while at the same time adapting himself to his environment; our concern has been to understand how this "vital balance" is achieved.

Early in the course of the B. M.'s development it was realized that unless we offer service we will not obtain subjects for study. Therefore the Institute decided to develop facilities to offer diagnostic and treatment services to children. But while the B. M. I. first offered services to children, it gradually developed services for adults, and at present adults and children are equally represented. In this past year 89 adults and 45 children have been evaluated at the Nirmala clinic; if we add to this 56 children with mental retardation, we see that the totals for adults and children are nearly equal. The service to adults grew as a response to needs of the community. This has also been the case with other services. In 1965, for example, Sharda, a special school for the mentally retarded, was founded as a response to a problem which the institute faced; until then we had seen, for diagnostic purposes, many retarded children, but there was little that we could offer them in terms of education because we lacked expertise. Sharda School, made up initially of only four children, was founded by a generous donation from Smt. Shardaben Chimanlal. The program was soon expanded, and today there are 50 children in the school. In its first years, Sharda offered its clients some education but did little to enable them to be relatively self-supporting. Because of this it was decided to start a rehabilitation program. With the aid of a research grant from the H. E. W. Department of the U. S. Goverment, a vocational training facility was established in 1973. So far 44 clients have received vocational training, and of these 9 have been placed in the community. In addition to rehabilitation work, the Occupational Therapy department is involved in developmental occupational therapy, occupational training for the emotionally disturbed, and counselling of parents. 127 patients have received help in this program. At present a workshop is being constructed in which about 75 handicapped persons will be trained and prepared for employment.

Besides the developmentally handicapped, in recent years very young children have been brought for evaluation. We have evaluated 56 children and 18 adolescent mentally retarded. Out of these 56 children, 25 belong to the age group 0–5.6 years. Because of this high percentage of young children we have been led to explore more precise evaluative procedures. Overall, the age range extends from about 8 months to 45 years and above. Therefore we have had to think about providing services for various age groups at different levels. A concrete expression of this concern is manifested in the decision to establish a center for the scientific study of developmental disabilities.

However, service for the retarded is not our only activity. During the year 1975–1976, the psychiatric unit has seen 45 children, 21 adolescents and 89 adults. Among children the problems range from learning difficulties to emotional disorders. Invariably, these problems are reflections of difficulties within the family, and consequently we have had to work with the family to bring about mutual adaptation between the child and family.

Among the 89 adult patients seen, 78 belong to the age group 18 to 47 years of age. 53 are males and 36 females. This pattern of male preponderance

is seen in all age ranges and in every clinical category. This forms a cultural pattern for whjch an in-depth study must find an explanation. Among 87 males (including adolescents), 50 are single. If we consider only adults, out of 60, 35 are single and 25 married. The significance of these findings merits closer study.

Our statistics indicate that more people come for help with neurotic conditions than with disturbances which may be technically described as psychoses. The majority of clients belong to the middle socio-economic group. This is the concerned group as well as the one most likely to be affected by social change. We do not know if this is an indication of things to come, but we are interested in finding out,

Evaluation of a psychiatric problem is a complex affair. We depend upon a variety of skills including clinical, psychological and social work expertise. The social worker provides a perspective on the family milieu and social background within which the individual may be better understood. Similarly, the clinical psychologist makes a contribution towards the understanding of the total human being. Apart from servicing the various units within the Institute, the department has provided consultation services to various agencies in the community, either for selection of candidates of a training program or for consultation for educational television. The clients are varied; a school, a special training center, an organization, an individual with a specific problem, and our own units within the Institute.

The speech and audiology unit was established in 1966 with 24 patients. During the year 1975-76 approximately 800 patients with speech and hearing problems were seen. They came from Ahmedabad and other areas of Gujarat, as well as from neighbouring states, since this is the only center between Bombay and Delhi. The expanded speech and audiology unit sees its role as developing refined techniques and providing consultation. Once a month a diagnostic clinic is conducted at the Bhavnagar school for the deaf. we can now test the hearing abilities of babies of one month.

Understanding the process of illness has two dimensions; one is the out-patient level, and the other is the residential facility. Since 1970 we have been running a day-hospital which was started as a pilot project before establishing a full hospital service. The approach to treatment in the day-hospital provides a therapeutic environment which incorporates the physical set-up, the activities pattern and the attitude of the staff. Because the building is small we can not admit more than 12 patients at a time. The people we treat are relatively severely disturbed and need to get away temporarily from their own environments in order to reconstitute themselves. The families also require help to understand the nature of the illness so that they can accomodatate the patient when he goes back into the family. During the past year 25 persons have been newly admitted while 12 have been carried over from the previous year. 27 males and 10 females are represented within an age range of 18 to 45 years. The average stay of patients in the day hospital is approximately 37 days. According to international standards this is a positive index. This facility will be extended to a full hospital service as soon as the buildings are complete and new personnel trained. Our aim is to establish a facility where people can come for treatment without feeling the stigma attached to emotional illness.

In the psychiatric service one of our most important treatment modalities is psychotherapy. This requires expertise. On an average approximately 100 patients of all age groups come for psychotherapy every week. This mode of treatment is gaining recognition, as is evidenced by the fact that we conduct a training program in psychotherapy under the auspices of Gujarat University; this is the only one of its kind in India.

psychotherapy is a broad term incorporating varied approaches such as individual and group therapy, play therapy for children, marriage counselling and family therapy etc.

As we learn more about problems which we treat we realize that research is a necessity. Research ought not to be an esoteric discipline but a vital activity providing answers to questions that baffle us either in evaluation or in treatment.

In an academic setting a well-stocked library is a necessity. At present we have approximately 5020 books and 2015 bound journals; 106 journals, both national and international, are subscribed to. There are 16 films of educational interest. We are fully equipped with audio-visual equipment which is used primarily in our training program. Our library is recognised as a specialized library in this part of the country. Requests for information are received from various individuals and institutions from all over the country. This necessitated the establishment of a documentation unit, which is still in its infancy.

Among our educational activities is Balghar, a primary school which aims at providing comprehensive education to children. The education is directed toward overall growth. More will be said about this in our report on educational and training activities.

At this point we wish to express our gratitude to the State and Central governments and to Gujarat University. They have responded to our needs with generosity and understanding. Our thanks are due also to the trustees, who have given unstinted co-operation.

The past decade has been eventful; we have seen phenomenal growth in our activities. This development was not strictly by design. Many interacting forces have led us on this path, and we can only hope that we will continue to remain open and dynamic. In this endeavor all the people working here are partners, and the community can claim no mean share in our hopes for continued usefulness.

EDUCATION

Education at B. M. Institute is an integral part of the total function. It is conceived as a built in dynamic process providing educational experience to the recipient of services and the professionals who gave such services. Normal and non-normal children are provided comprehensive educational facilities with the total human development concept in mind.

BALGHAR

Balghar is one such experiment which started in the year 1949 as a nursery and primary school for normal children. It was one of the first activities of the B. M. Institute, total mental health program. Since its inception, the aim has been to study how children grow and develop in our culture. The aim has also been to work towards creating an environment and evolving teaching methods which have at their center respect for the growing child and creation of conditions for the children to develop at their own pace without an outside imposition. The first decade of the child's life is seen as a foundation in which both home and school extend into each other to create a stimulating environment for the actualization of the child's potentials. Exposure to and experience in real life situations through regularly planned trips which are followed by self expression through the media of creative arts or spoken and written words are part of teaching methods. In such an atmosphere learning becomes pleasurable. There are 109 children in the school 14 in the prenursery and 30 in nursery sections and 65 at the primary stage.

We have observed the traumatic experience that the child goes through as he separates from the mother

to go to nursery school at three years of age. The abrupt discontinuity of the child's separation from the home often is a critical factor which influences the child's orientation to school and learning. It was with this concern that the pre-nursery program was started in 1971. These children are taken in at 2-1/2 years of age for a one and a half hour morning program. Mothers stay with the children and thus both the child and the mother have an opportunity to familiarize themselves with the school. The child's exploration of the play environment is facilitated because of the mother's presence.

During the year we have made an attempt to be systematic about observing pre-nursery children in various areas of their development in the context of the mother-child interaction, On the other hand, mothers in a discussion group have explored, with the help of a team of workers, the meaning of behaviour such as stubborness and clinging. We hope to publish this pre-nursery program case study.

If, on the one hand, we have gained insight into early childhood, we are also concerned with issues of a larger nature : for example, how traumatic is the separation experience for the child of 2-1/2 to 3 years of age, particularly in view of the dependency we seem to foster in our families ? Given the extent of this trauma, what is the value of pre-nursery school programs? There is no denying the fact that an increasing number of families do send their children to pre-nursery schools. Does this reflect changes in the structure and function of the family ? What are its implications for the mental health of the child and the family ? Does it mean that the modern Indian family is a relatively more open system than the Indian family of earlier days ? If this is so, then the school system must be prepared for contact with the family beyond the proverbial parent teacher association. It is perhaps more than a coincidence that we are beginning to raise similar questions in our clinical studies of children and families with psychiatric problems. We hope that we will be able to document our experiences with normal and clinic-referred children and families for the meeting of the International Study Group of the International Association of Child Psychiatry and Allied Professions, to be held at the B. M. Institute in late 1977.

SHARADA

As mentioned earlier, the child guidance clinic which functions as an integral part of the mental health services of B.M. Institute brought to light many children who were not normal. A good proportion of these non-normal children were mentally retarded. In the early sixties an intensive need was felt amongst the professionals as well as the parents of the retarded children and community at large that some services should be offered for such retarded children. As a result, and after much deliberation, the Institute decided to launch a specialized service for the care, education, training and rehabilitation of the mentally retarded. This was formally established to provide diagnostic services and parental counselling. Diagnosing a case and providing support to the parents was found to be inadequate and therefore a school for the retarded was proposed. Responding to this pressure from the community, "Sharada" was established. Sharada is a day care center for the mentally retarded which was inaugurated on 21st March, 1965 with the blessings of Smt. Sharadaben Chimanlal. The school started with four children and this number was soon increased to ten. With the school there grew up a complex of services for the retarded.

During the past year Sharada had 44 children in the age range 6-14; this number represents a fraction of the demand for admission to the school. The program is geared towards achievement of social and

emotional compentence. A variety of activities are introduced for speech and language development. Reading, writing and number work are given when the children are ready and are related to practical day-to-day living situations. Older children are exposed to activities leading to learning of basic skills necessary for vocational education. Self expression through creative media has an important place in the total school program.

Over the years we have gone through stages in our understanding of the education of the retarded child. In the initial years sympathy was the center of the approach; this often implied low expectations of the child even though he or she may have had potential for higher achievement. The program that the child was given lacked stimulation in correspondence with the expectations of a child at a similar chronological age. Fortunately, certain workers became sensitive to these dangers, and expectations were brought into congruence with our better understanding and assessment of the child's capacities.

This understanding has initiated for all members a process of rethinking the programming for the retarded. Revision of the program will extend to both ends of the primary school phase. The pre-primary section will accept children at around three years of age. Sixteen children in the age range 3-6 years, who are already in occupational therapy, will now also have an educational program jointly offered by a teacher-occupational therapist team. The post primary group will be another extension and will take in adolescents in the 14-18 year age range; this will also have a vocationally biased educational program. About eighty children at various educational levels may receive this educational service.

This reorganized program has just been launched and the children have reacted quite positively. It is a reorganization that the workers will take some time to incorporate into their system. A common language is yet to emerge. We will need time to readjust our professional boundaries and form a team identity.

Finally, during the year the teachers of Balghar and Sharada came together as a teaching discipline. They discussed various issues related to normal or developmentally handicapped children. Among a few integrated programs that the group worked was the transfer of a particular child from Sharada to Balghar. The child has used the Sharada program optimally and was ready for a more stimulating educational milieu in terms of academic and peer group demands.

Sarla Center for Professional Education

Training for mental health professions involves responsibility for the client. It also involves responsibility for other aspects of service, expecially teaming up with members of other disciplines and the organization of services in such a way that the service becomes technically sound and reaches the client in a manner and at a time when he can accept it. Such training requires dealing with clients. Learning here is by doing; learning and work are concurrent.

This approch to training grew over a period of more than two decades of mental health services at B. M. Institute. The Institute had always required personnel trained in a psychodynamic orientation. Continued staff development programs through supervision, case conferences and workshops on theoretical problems relevant to practical issues deepened our understanding of the approach. It was extended to short-term training programs, to pediatrics students for an orientation in child psychiatry and to social work students in block placements. Training-learning through supervised practice became the model which we found valid over the years. Service is at the foundation of this approach.

Learning to practice as one takes on clinical responsibility is its orientation. Such training was formalized by the establishment of the Sarla Center for Professional Education in 1972. With it we extended training to post-graduate programs leading to degrees awarded by Gujarat University.

A deliberate attempt has been made to facilitate the visits of consultants and leading experts in the field. This has helped in developing up to date skills and the exchange of ideas at national and international levels. This year the Institute is fortunate to have Mrs. T. S. McConnel, from Queensland, Australia, who is involved in research and teaching at the department of Child Health, University of Queensland. Mrs. McConnel, who had first come to B. M. Institute in the year 1972, as a visiting consultant to the fourth all India conference on mental retardation sponsored by the rederation for the Welfare of the Mentally Retarded (India), revisited the Institute in early 1974 for a brief period of six weeks. This visit greatly helped us in translating the concepts form development psychology into a spectrum of services for the developmentally handicapped, infants, adolescents, and adults. This year the Institute is fortunate to have Mrs. McConnel again as a full time consultant and teacher for co-ordinating the one year course on Scientific Study of the Developmentally Handicapped jointly sponsored by the B. M. Institute and Federation for the Welfare of the Mentally Retarded (India). About 20 trainees from various disciplines had been sponsored to undertake said course.

To review the last year in terms of advanced training we are pleased to put on record that 18 trainees have graduated from this Institute in various disciplines like psychotherapy, psychiatric social work, clinical psychology, special education, speech therapy and audiology and psychiatric occupational therapy.

We often express concern over the pace of expansion and development of multifarious programs, knowing well that such new ventures have to be led by a handfull of senior staff. A more rational policy has to be evolved to balance the need for such expansion and the available resources.

CLINICAL SERVICES

Nirmala Clinic for the emotionally disturbed.

Diagnosis - evaluation is a multi-disciplinary function. Usually the team consists of a psychiatrist, clinical psychologist and a psychiatric social worker. The occupational therapist or a speech therapist is called upon for consultation wherenever it is indicated. Extended observation-evaluation as a diagnostic tool has been more frequently used during the years to arrive at a definitive diagnosis. Such an observation has been carried out by a child development specialist in a group setting or by a clinical psychologist. Often day hospital setting is used for this purpose. The diagnosis are arrived at and the treatment plans made in the weekly intake or diagnostic conferences. Besides fhe quantitative aspects of diagnosis in terms of the several man hours spent, therapeutic elements in evaluation have been emphasized. The initial contact by the team with the patient and the family lays the foundation for the future therapeutic effort. It is gratifying to note the reduced drop out rate during or after the evaluation due to this awareness.

Twice as many adults as children were seen in the emotionally disturbed category of patients; this is an emerging trend we have seen over last couple of years. The most frequent diagnostic category is psychoneurosis and psychosis followed by personality disorder and special symptom disorder. A total of 183 cases received psychotherapy. Of these 120 cases are currently in continued treatment and 63 were closed during the year with varying degrees of improvement.

Treatment recommendations were more specific as compared to previous years. The treatment modalities include individual therapy, short term psychotherapy, supportive work, psycho-educational work, group and family therapy besides work with parents. Short term work seems to be the treatment of choice in crisis intervention and young adults seem to have used it satisfactorily. We are also moving in the direction of group therapy and therapy groups of children, pre-adolescents, young adults, adults, parents, and a relaxation group have been formed. In several cases a specific recommendation of psycho-educational work for children was found acceptable by parents who used it satisfactorily. The service delivery system is geared to the changing needs of the community.

Godavari centre for family relations.

Godavari Center for Family Relations was established in March 1965 with the purpose of focussing our attention on the family interaction patterns and how they affect the individual adjustment. Since the identified patient received the attention, which he deserved in the various clinical services it was felt that the family may recede into the background. It would not be construed that the family did not receive due recognition prior to the establishment of G. C. F. R. The service only made us look into the family more specifically. Since then we have come a long way in the sense that it is now our conviction that irrespective of the nature of the problem our services to the patients will be more effective if we work with the family members concurrently. In almost all the units of the Institute work with the families is done at various levels, either individually or at a group level. In this way the families involvement with the treatment programme is sustained and they will be better prepared to help the patient to readjust to the family milieu with an enhanced status. It is seen, thus, that all the clinical services have, more or less, adopted the goals of G. C. F. R.

The staff is working on a research project to study the processes of the interaction in the families on a more empirical basis. This, hopefully, would provide us greater insight into the family dynamics and allow us to sharpen our clinical skills.

Day care unit for the emotionally disturbed

The institute has registered many cases which, although they need hospitalisation and day a care programme for improving their functions cannot be referred to total institutionalization or long term total hospitalization. Diagnostic categories like conversion reaction and schizophrenic reaction - paranoid type often indicated the need for an opportunity to interrupt with a milieu therapy team comprising of psychiatric nurses, an occupational therapist, a clinical psychologist and a psychiatrist. This became the function of the day care unit for the emotionally disturbed. Individual therapy and treatment in the out patient therapeutic groups during and after hospitalization have been offered to several patients. The crucial factor in this helping process is to return the patient back to his family and community life. The short term day hospitalization has facilitated this process in the majority of cases. The emphasis is not only to rid the patient of his symptom but help him regain functional competence. There is fundamental conviction that this cannot be achieved unless the families are involved from the beginning in the treatment - rehabilitation process.

Clinic for the mentally retarded

As mentioned earlier this clinic has been functioning since 1965 and it encompasses many specialised services for the mentally retarded viz. education programme, pre-vocational and vocational training programme, speech therapy, occupational therapy, social

work services, psychiatry and consultation. The diagnosis and assessment of the functional potentials of the mentally retarded individuals consumes more man hours involving many specialists to arrive at a reasonably accurate assessment. Considerable time has been spent to develop more sharpened, meaningful and effective tools which could be economically used for the assessment of the individuals. Among the diagnostic categories we still continue to see many brain damaged individuals whose retardation is secondary to brain damage. This consistent finding over the years is very disturbing since such unfortunate sequelae can be prevented by better antenatal care and pediatric supervision during the early growing years. Need for preventive work can eliminate so may heart breaks subsequently.

A much more significant development during the last year has been the incidence of many children who are technically known as suffering from minimal brain dysfunction. These are the children who do not show any severe organic condition but show delay in development of various congitive functions. For instance, there may be delay in speech and language development, or percepto-motor difficulties which manifest in learning problems. Unfortunately, because of their indifferent academic performance they gradually lag behind the class average and are perceived as mentally subnormal children. This is a tragedy because if diagnosed early and remedial measures adoped in time, they can very well make up for their deficit and join the main stream of their peer group. We are developing new tools and techniques for an accurate assessment of such children and also providing the necessary remediation.

Sarvangi shishu vikas clinic

Sarvangi is one of the newest establishments of this institute which will do early intervention and prophylactic work with children upto 2½ years. The Sarvangi team consists of a psychiatrist, pediatrician, occupational therapists and developmental psychologists along with a peripheral team comprising of neurologists, neuro-surgeons, occupational therapists, psychiatrists, speech therapists, social workers and child development specialists, Help is also sought from other medical specialities and professions like nutritionists, public health worker and physiotherapist. This attempt has been made with the hope that such a comprehensive and timely made intervention would help in better growth and development of children.

Vocational rehabilitation service and occupational therapy clinic

It has been increasingly recognised by experts in the field that rehabilitation does not start at the stage of adolescence or young adulthood, in the life of a handicapped person. The responsibility of adulthood does not come about suddenly as one grows up. The preparation for adulthood has to start from early childhood so that an adequate foundation is made for adults to take up the responsibilities for effective living. It is desirable to initiate rehabilitation services at an early stage. Considerable training phases have to be telescoped in such cases so that they are made ready during shortest possible time. This requires a comprehensive and in depth study of the problem of rehabilitation in our context. We were fortunate to obtain a three year research cum demonstration grant from the Government of U. S. A. for taking up a study of this problem in a systematic order. Under this grant a vocational rehabilitation program for the mentally retarded youth was established in the year 1972. Working in this programme, it was realised that the potentials of mentally retarded were under estimated and many of them could be rehabilitated and grainfully employed in the community. This project also brought helped in developing a sheltered workshop for the rehabilitation of mentally retarded young

adults. Government of India provided a timely help in developing a full-fledged workshop for work exper ience and sheltered employment. This programme is known as Multi-category Rehabilitation Centre which has now started functioning under the financial assistance from the Government of India in the 5th Five Year Plan.

In this rehabilitation service the occupational therapy clinic provides diagnostic and treatment services to mentally retarded and emotionally disturbed children, adolecents and adults on an out patient basis.

Audiology and Speech Clinic

One of the ten centers in India and one of the three training units in the country, the speech and audiology clinic was estabilished in 1966. If we see the statistics, the development of this unit is very striking. In 1966, 24 cases were seen whereas the current statistics show 557 people having availed of our services. These figures indicate that this unit is serving a very useful function in meeting with the demands of the community. As the unit is equipped with highly sophisticated equipment, very intricate audiometric investigations can be carried out. Referrals come from both the general hospitals and private consultants. Occasionally medicolegal cases are also referred to the unit.

In some cases a speech problem is only a manifestation of deeper emotional difficulties and environmental stresses. In such cases apart from speech therapy other treatment measures have to be considered. The uniqueness of the speech unit in a psychiatric setup is the availability of resource personnel belonging to other disiciplines. This promotes free exchange of ideas and encourages a holistic approach to the problem.

RESEARCH

Research has been a component part of the Institute's activities since its very inception. Since the primary focus of the Institute has been on providing services to the community, the researches were basically clinically oriented. This year the institute is glad to put on record the 3 year research programme cum demonstration study namely BMI-SRS Project for the Rehabilitative Assistance to Mentally Retarded Youth (Jointly sponsored by B. M. Institute and Social & Rehabilitation Service of the Dept. of Health, Education & Welfare, Washington D. C., U. S. A.) under the Research grant No. 19-P-58172-F-01. This study has brought about a better understanding of the rehabilitation process and the study of the problems of the mentally retarded adolecents and adult individuals. We hope that this study would be able to develop a rehabilitation process more suitable to and effective in our conditions.

PRINTING PROCESS
Multi-category Rehabilitation Centre
B. M. Institute of Mental Health, Ahmedabad-380009. India.